IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
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FEB 10 2009

February 9, 2009

RECEIVED

FEB 23 2009

FACILITY STANDARDS

Kathy Prophet
Preferred Community Homes - Bedford
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Bedford, Provider #13G039

Dear Ms. Prophet:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Bedford, which was conducted on January 26, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 23, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by February 23, 2009. If a request for informal dispute resolution is received after February 23, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MATT HAUSER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G039	A. BUILDING _____ B. WING _____	01/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - BEDFORD	398 EDGAR COURT MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Matt Hauser, QMRP, Team Leader Sherri Case, LSW, QMRP Common abbreviations used in this report are: QMRP - Qualified Mental Retardation Proffessional	W 000	"Preparation and implementation of this plan of correction does not constitute admission or agreement by Bedford with the facts, findings or other statements as alleged by the state agency dated January 26, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Bedford – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure evacuation drills were conducted quarterly for each shift for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for the facility and staff not being able to determine individuals' responses or identify problem areas. The findings include: 1. During a review of the facility's evacuation drills on 1/22/09, the following was noted: - There was no evacuation drill completed during the third quarter (July, August, September) for the grave-yard shift (11:00 p.m. - 7:00 a.m.). - There was no evacuation drill completed during the third quarter for the P.M. shift (3:00 - 11:00 p.m.). When asked during an interview on 1/22/09 at	W 440	**W 440 483.470(i)(1) EVACUATION DRILLS** The facility will ensure that evacuation drills will be completed at least quarterly on all shifts for each shift of personnel. Staff training will be implemented on firedrills and the regulations that must be followed for this facility. A monthly review of evacuation drills will be completed by the AQMRP of the facility. Person Responsible: AQMRP, RSC Completion date: ~~5-23-09~~ 2/26/09 – pen and ink revision to completion date per Administrator on 2-25-09 by Matt Hauser RECEIVED FEB 23 2009 FACILITY ST	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kathy Knight | Administrator | 2-20-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 440	Continued From page 1 12:25 p.m., the Home Manager stated the drills could not be found and she was unsure why they had not been completed. The facility failed to ensure evacuation drills were conducted at least quarterly on all shifts.	W 440		

Bureau of Facility Standards

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MM337	16.03.11.110.04(c) Fire Drills A minimum of twelve (12) unannounced fire drills must be held annually, irregularly scheduled throughout all shifts. In addition, a least one (1) drill per shift must be held on a Sunday or holiday. This Rule is not met as evidenced by: Refer to W440.	MM337	MM337 16.03.11.100.04 (c) Fire Drills Refer to W440	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include: During an environmental review, conducted on 1/21/09 from 10:30 - 11:00 a.m., the following concerns were noted: - There was a 12 inch diameter stain in the carpet in the living room. - There was a puddle of water under the sink in the kitchen from an apparent leak in the drain pipe. - There was exposed wood, an uncleanable	MM380	MM380 16.03.11.120.03(a) Building and Equipment The 12 inch stain is being addressed and new carpet is scheduled within the next 6 months for this facility. Completed by 7-26-09 The puddle of water was cleaned up and maintenance fixed the leaky faucet. Completed on 1-26-09 The uncleanable surface of exposed wood under the kitchen sink was addressed and a clean surface now replaces the exposed wood. Completed on 2-18-09 The food splattered on the kitchen cupboard with the cups and on the door of the Lazy Susan cupboard was cleaned off. Completed on 1-26-09 The baked grease, an uncleanable surface, on two muffin tins was cleaned and is no longer present on the tins. Completed on 1-26-09	

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FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-20-09

Bureau of Facility Standards

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MM380	Continued From page 1 surface, under the sink in the kitchen. - There was what appeared to be food splattered on the kitchen cupboard with the cups and on the door of the Lazy Susan cupboard. - There was baked on grease, an uncleanable surface, on 2 muffin tins. - There was dried on food on 2 Pyrex baking dishes. - The sink in the back bathroom was slow to drain. - There were no less than 6 quarter inch chips in the paint on the living room wall (towards the bedrooms).	MM380	The dried food on 2 Pyrex baking dishes was cleaned off. Completed on 1-26-09 Maintenance was called and the sink in the back bathroom no longer is slow to drain. Completed 1-26-09 The living room walls are scheduled by maintenance to be repainted. Completed by 4-26-09 ~~Except Carpeting & Painting~~ error Pen and ink revision: Will be monitored monthly by RSC; with the exception of the carpeting and paint which will be monitored by the Administrater - per the Administrater on 2-25-09 by Matt Hauser	